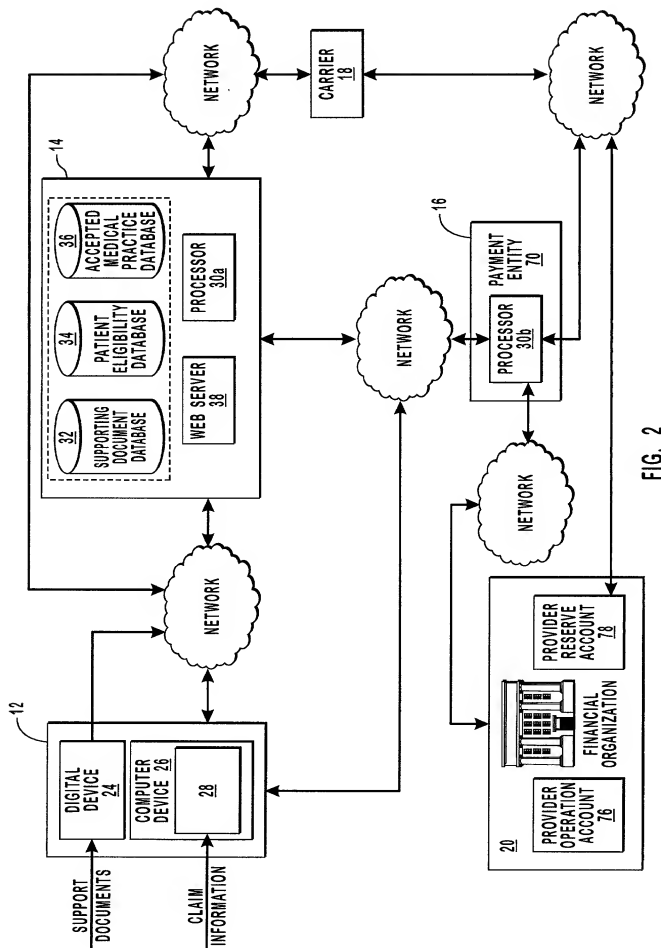


FIG. 1



28a

Health Care Claims Form	
Plan I D	
Insured's I D	
Paitent's date of birth	- mm/dd/yy
Provider I D	

FIG. 3

Health Care Claims Form

Plan ID : 1234

Insured : Doe, John 541XXXXX

Patient : 01, Jane

Provider: MISCELLANEOUS PROVIDERS

Please enter the Patient Dependent Number from above from above:

Last Name, First, Middle Initial, I.D.

Referring Physician

Service Provider

Diagnosis or Nature of Illness or Injury.

Dates of Service

Place

Type

Procedure, Service or Supplies

Diagnosis No

\$Charges

Patient's Account

Accept Assign?

Total Charge

Amount Paid

Balance Due

FIG. 4

2013

